

Letting Steam Out of the Pressure Cooker: The EMDR Life Stress Protocol

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The standard protocol of eye movement desensitization and reprocessing (EMDR) therapy has been well established as an efficacious brief treatment for posttraumatic stress disorder (PTSD), addressing past, present, and future aspects of a traumatizing event. This article provides instruction in the administration of the EMDR Life Stress Protocol, which targets a significant recent experience or a life scenario that is not necessarily remarkable as a stand-alone event (getting up every morning with dread, feeling anxious about leaving the house) and which causes distress and impaired function such as has been commonly reported during the COVID-19 crisis. This protocol involves minor but significant modifications within EMDR therapy's standard procedures. It uses the present-day experience as the Target Memory while accessing briefly, the memory network of historical experiences that inform the client's reactions to their present circumstances. Successful processing is immediately followed by a Future Template to generate an alternative pattern of response, optimizing the client's capacity to respond adaptively to continued life demands. The EMDR Life Stress Protocol differs from EMDR's various recent events protocols, which seek to reduce posttraumatic symptoms following a recent traumatic event or crisis. Those protocols focus on the critical incident and ancillary events, and typically do not intend to activate memory networks of related historical experiences. The article describes case conceptualization to offer a rationale for this approach and provides a detailed description of this protocol, illustrated with case examples, highlighting its application both as a psychotherapy approach and as a brief intervention.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; EMDR Life Stress Protocol; crisis intervention; brief treatment; recent traumatic events; attachment

This article describes a way to work with recent traumatic events or ongoing life stress using eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2018). Originally, the EMDR Life Stress Protocol was developed to work with complex clients who struggle with attachment issues as part of a more comprehensive EMDR psychotherapy (Laliotis, 2007, 2010). This modified approach has been more recently applied as a stand-alone EMDR treatment protocol for clients struggling with the current COVID-19 crisis (Laliotis, 2020).

Shapiro's (2018) Adaptive Information Processing (AIP) model asserts that an individual's response to their current situation is informed by past experiences that are similar in nature. When these past experiences

are adaptively stored in memory networks, the learning that comes from these memories can be effectively applied to current stressors that resemble these past experiences. When past experiences are inadequately processed and maladaptively stored due to high levels of distress and arousal at the time, or the failure of significant others to respond appropriately, the learning that comes from these experiences is also maladaptive, informing the individual's reactions to similar situations in the present. Since memory and learning are associative, the brain automatically makes these past-present connections which inform how we think, feel, behave, and perceive situations in the present. Based on this foundational tenet, it stands to reason that treatment of current stressors that allows access

to some of the earlier memories driving the client's reactions will facilitate generalization of treatment effects and memory consolidation. This can then be expected to increase the client's stability and resiliency in responding to similar circumstances in the future, especially if the stressors are ongoing, as is the case with COVID-19.

Crises and Stressors

Crises and stressors are a part of life and can take many forms. While they are inherently taxing due to the disruption they cause, the danger they may pose, or the ongoing challenges about the present and future, our ability to respond adaptively determines the degree of impact these stressors will have (Lehrer, Woolfolk, & Sime, 2007, 2020). From an AIP-informed perspective, when previously stressful experiences are inadequately processed, a person will likely have more difficulty responding adaptively to their current life stressor(s), decreasing their capacity to cope, increasing their distress and the likelihood of responding maladaptively in the future (Solomon, Laliotis, & Shapiro, 2020). With one's capacity to respond adaptively further diminished, there is a greater likelihood of suffering from a physical or mental disorder, such as acute stress disorder, posttraumatic stress disorder (PTSD), anxiety, or depression.

It is well established that the ability to respond to life changes, challenges, and obstacles is central to maintaining a sense of psychological and emotional well-being. A person's premorbid level of functioning predicts to some degree one's ability to respond adaptively to stress, particularly if they have a history of psychiatric illness (Jeong et al., 2016). Life stress, especially if it persists for prolonged periods, can have a negative impact on anyone's sense of well-being. Symptoms of stress include but are not limited to mood fluctuations, such as anxiety and depression; bouts of anger, irritability, or restlessness; feelings of overwhelm or shut down; lack of motivation or focus; excessive worry, sometimes accompanied by catastrophic thinking; sleeping too much or not enough; difficulty concentrating; having trouble with memory, loss of appetite or eating too much (Marroquin, Tennen, & Stanton, 2017). Other manifestations of stress include somatic complaints, such as digestive issues, headaches, stomach aches, chest pains, and muscle tension, as well as changes in heart rate and blood pressure. Ongoing stress can also have an impact on one's ability

to think, feel, and behave appropriately in response to daily life tasks and demands. Without addressing the sources or the effects of stress, the cumulative result over time impacts one's physical, mental, and emotional health, sometimes with dire consequences, overwhelming resources and exacerbating underlying weaknesses.

The current COVID-19 crisis is a stressful time for most everyone and is inherently challenging for many reasons. The fear of contracting the virus or infecting others, particularly family and coworkers, looms large, especially for those who are in jobs that require them to leave home in order to perform their duties (Cava, Fay, Beanlands, McCay, & Wignall, 2005). Some develop catastrophic reactions to physical symptoms experienced during the quarantine period (Rubin et al., 2016). The financial strain caused by unemployment, loss of a small business, or greatly reduced income generates fear and uncertainty about the future. Parents who work and have to attend to their children while quarantined at home are managing competing demands without access to their usual resources (Sprang & Silman, 2013). The isolation of social distancing and stay-at-home orders can be a significant stressor (Manuell & Cukor, 2011), particularly for people who have a complex trauma history or live alone without any physical contact. Given that our neurobiology is geared for social contact and human connection, over time these stressors will likely have a significant negative impact for many people (Wu et al., 2008). We also know from previous studies on the effects of quarantine (Brooks et al., 2020) that additional stressors such as extended stay-at-home orders and inadequate supplies and information provided by authorities add considerable stress to the inherent uncertainties of a public health crisis. Perhaps a less obvious effect of quarantine is the disappearance of "place" or the loss of "place attachment," an emotional bond to a physical space that we assign meaning to (Moser, Moser, & McNaughton, 2014). The importance of a sense of place has been observed across cultures and offers significant psychological benefits. Neuroscientific research by Moser et al. identified certain neurons described as "place cells" and "border cells," that help us manage autobiographical memory through memories of people and events that occurred in the places we frequent. It explains the common experience of one day being the same as the next, combined with a subsequent loss of identity that we derive from being in a familiar place, such as going to work, school, or a place of worship.

Common Interventions for Life Stress and Crisis Intervention

Typically, when a client is in a crisis, the general consensus is to offer interventions that are specifically designed to stabilize the individual (Roberts, 2005). Common interventions include generic skill development, such as affect regulation, breathing exercises, relaxation, meditation, yoga, tai chi, and other mindfulness practices. The purpose of these interventions is to help the client tolerate the situation and to provide momentary relief. In some treatment approaches, such as cognitive behavioral therapy (CBT), the therapist may prescribe specific strategies to counteract maladaptive thoughts and behaviors with the goal of helping the client cope with the situation more effectively (Datillio & Freeman, 2007). In either case, the techniques or interventions applied provide temporary relief but do not address the underlying causes of the individual's reaction to their life stress. Therefore, the client's underlying vulnerability and susceptibility remain and are likely to be triggered again.

EMDR Therapy

EMDR therapy (Shapiro, 2018) is recognized as an efficacious treatment for PTSD and is considered by many international associations as a front-line trauma treatment (e.g., International Society for Traumatic Stress Studies [ISTSS], 2018). It is also applicable to a broad range of clinical issues across a variety of different treatment contexts (Shapiro & Laliotis, 2011). As a comprehensive psychotherapy approach informed by the AIP model, it theorizes that difficulties in the present are informed by past experiences that are inadequately processed and maladaptively stored. EMDR therapy's three-pronged protocol addresses past, present, and future by treating the neurophysiological storage of memory, allowing the targeted memory and other, similar memories to be reprocessed and successfully integrated with other, adaptively stored experiences. This ensures comprehensive treatment effects by reprocessing disturbing past experiences that inform current difficulties, targeting present triggers that remain disturbing due to second-order conditioning, and generating future templates of action to optimize one's capacity to respond adaptively to future challenges (Shapiro, 2018).

There is an 11-step procedure for memory processing that includes Phases 3–7 and is standard in EMDR therapy (Shapiro, 2001, p. 222). It involves fully accessing the targeted memory as it is currently being

experienced and taking baseline measurements of the salient components. These components include the image that represents the most disturbing part, the negative belief about self as it pertains to the memory, the desired belief about self, and the degree of believability the desired belief holds at the outset. The validity of the desired belief is rated using the Validity of Cognition (VOC) scale, from 1 (*completely false*) to 7 (*absolutely true*). The client's current emotions and sensations are identified and measured with the Subjective Units of Disturbance (SUD), using a scale from 0 (*calm or neutral*) to 10 (*most disturbing*). The client also identifies the location of body sensation.

During EMDR processing, sets of bilateral stimulation (BLS) are administered using visual, auditory, and/or tactile modalities, while the client is instructed to focus on the memory and the associations that spontaneously arise. Simultaneously, the client is instructed to maintain dual attention between the present and past throughout the process. Once the Target Memory has been successfully reprocessed, as reported by the client and measured using the SUD scale (calm, no disturbance reported), the therapist links the desired positive belief with the newly neutralized memory until the emotional linkage to the positive belief is strong and congruent with the body as measured by the VOC. A clear body scan indicates no somatic disturbance as the client holds the memory and the positive belief in mind, ensuring complete resolution of the targeted memory. The three-pronged protocol of past, present, and future ensures treatment generalization for present triggers and similar situations in the future.

EMDR Therapy for Recent Events and Ongoing Trauma

Numerous EMDR treatment protocols have been developed to reduce symptoms of acute stress that follow a critical incident, with at least seven randomized controlled trials showing their effectiveness in decreasing posttraumatic symptoms (see Shapiro & Maxfield, 2019, for a review). These recent event protocols have also been used to treat posttraumatic symptoms in situations where the trauma is ongoing. The types of trauma patients included cancer survivors (e.g., Jarero, Artigas, Montero, & Lena, 2008; Roberts, 2018); bombing victims (Shapiro & Laub, 2008); and refugees (e.g., Korkmazlar, Bozkurt, & Tan Tunca, 2020; Lehnung, Shapiro, Schreiber, & Hofmann, 2017; Lempertz et al., 2020). These protocols have been administered to both adults and children and in group and individual settings. Outcomes are

promising, showing significant reductions in symptoms of posttraumatic stress.

EMDR Therapy for Life Stress and Ongoing Crisis

The EMDR Life Stress Protocol was initially developed by this author to address maladaptive patterns of response related to attachment styles rooted in developmental trauma (Lalotitis, 2007, 2010). Clients with developmental trauma and attachment issues often experience daily life tasks and relationship demands as stressful, exacerbated by their maladaptive reactions linked to memory networks containing unresolved painful memories. The protocol was developed to directly target these patterns of response as they manifest in the client's daily life, as one part of a comprehensive treatment plan in EMDR psychotherapy. The expected outcome is a decrease in problematic behaviors, without comprehensive processing of the complete memory network.

The EMDR Life Stress Protocol can also be applied as a stand-alone intervention for clients requesting brief treatment. Such clients may be having difficulties coping with ongoing life stress in ways that are a departure from their usual responses, due to the unique demands of the situation. For example, caretaking an elderly parent during the pandemic can trigger a maladaptive pattern of response, such as getting overwhelmed, unable to make an appropriate decision about their care. The client's inability to respond more adaptively exacerbates their life stress, making it even more unmanageable. It is clinically more expedient, therefore, to target the current situation where these maladaptive reactions present without fully activating the earlier memory networks. The EMDR Life Stress Protocol was exported from its initial attachment-based application in EMDR psychotherapy as a response to the emergent clinical demands stemming from the COVID crisis.

Treatment Conceptualization

Shapiro's (2018) AIP model views inadequately processed and maladaptively stored memories as the root cause of most pathology. In addition to recognized mental health disorders, symptoms can include unremitting emotional distress, dysfunctional patterns of behavior, or medically unexplained somatic symptoms. When current events or conditions share similarities with past experiences, the individual may react in ways that exacerbate their current difficulties, making it even more challenging for them. These

past-present collisions are the source of the client's symptoms and the corresponding memories are the focal point of EMDR therapy.

The goal of this protocol is not only to address the client's reaction to the current situation that is generating symptoms, but to decrease the emotional load from some of the earlier memories that intensify the client's reactivity to the current situation. By titrating access to these channels of associations, the emphasis is more on reducing disturbance related to present-day situations and preparation for likely future scenarios, which are the primary goals when dealing with an acute crisis situation or ongoing life stress.

Procedural Steps

The procedural steps for the EMDR Life Stress Protocol are the same as those used in Phases 3–7 of Shapiro's standard protocol (Shapiro, 2018), with three exceptions:

- The Target Memory is a recent experience or scenario (defined here as any situation that is unremarkable as a stand-alone event, but trigger the person).
- The Desensitization Phase includes more active interventions on the part of the therapist to access and limit channels of associations to include the Floatback technique. The therapist redirects the client back to the Target Memory more frequently, keeping the focus on resolving the client's reaction to their current situation.
- Installation of a Future Template of the same scenario or similar situation immediately follows the resolution of the Target Memory (SUD of 0; VOC of 7; clear body scan). While this is not a departure from the standard protocol, there is an added emphasis on immediately generating an alternative pattern of response to optimize treatment effects by offsetting the strength of the patterned reaction.

Case Illustrations

In this section, the use of this EMDR Life Stress Protocol for an ongoing crisis is illustrated by describing its application to three different case presentations. Non-essential details in the cases are changed to protect the clients' anonymity and pseudonyms are used. Two cases highlight the use of the protocol as a brief intervention, while the third case shows how it can be incorporated into a comprehensive treatment plan. The first case is a client who initiated treatment

specifically in response to the demands of staying at home during the COVID crisis. He has no significant history of developmental trauma and his presenting complaint only surfaced as a reaction to the current crisis. The second is a doctor who is experiencing traumatic stress symptoms from exposure to a number of current, big “T” traumas. She reports her patients are dying at a high rate from COVID with no treatment protocols or a cure for the disease. While she reports some developmental trauma, her history is not remarkable in this regard. The third case is about a client whose anxiety has significantly increased during the crisis and who has a history of complex trauma. She has been in EMDR psychotherapy weekly for a period of 9 months to address her self-esteem issues, relationship difficulties, and affect dysregulation. She does not have a dissociative disorder. In all cases, as is standard, the therapist initiates the treatment process through comprehensive history-taking and preparation measures, thereby assessing the client’s capacity and readiness for processing. Clinical decision points are highlighted to distinguish between the standard procedural steps and where a modification is being introduced.

Case One: Brief Intervention for Anxiety

“Jon” is a 42-year-old man who lives with his wife and two children. He and his wife work full time in an academic setting. He has no remarkable trauma history, although he reports having some social anxiety as a child. Jon has a limited social support system, and mostly he and his wife socialize with a few couples. Since COVID-19, he has been required to work from home while simultaneously navigating the demands of online home schooling for their children. In addition, a few people in his own neighborhood have tested positive for COVID-19. He is frightened to go outside his house, even for short walks with his wife, describing having a near panic attack at the thought. He has sought treatment to help him cope.

The Target Memory scenario is attempting to leave his house after almost 2 months of quarantine on the verge of a panic attack. The image is looking out onto his front yard from inside the door. The negative cognition (NC) is, “I’m not safe.” The positive cognition (PC) is, “I can be safe now.” The VOC is a 1. The emotions are fear and shame. The SUD is a 10 and the body sensations are tightness in his chest and stomach.

After several sets of BLS focused on the current anxiety, he reports a significant increase in his feelings of shame. The therapist is hearing his shame response as

a past-present moment, and asks, “Is feeling shame a familiar response for you?” “Yes,” he replies. Instead of allowing the processing to continue unimpeded as is usually the case, the therapist initiates an intervention called a Floatback, which is designed to bring into conscious awareness past memories that are similar in nature and are driving the current disturbance: “Would you be willing to let your mind float back to an earlier time in your life when you may have felt just this way and notice what comes to mind?” After Jon agrees, an additional set of BLS is administered. At the end of the set, the therapist asks, “What are you noticing now?” Jon proceeds to describe a memory of being cornered in the hallway in middle school by a group of boys, taunting him about being the new kid, not knowing what would happen. After additional sets of BLS, Jon reports two other associations: running into the house after walking home from school to get away from another group of boys that were seemingly following him and having nightmares as a kid. He reports that although he reached out to his parents for help, their response was “You’re old enough to figure it out on your own.”

After several additional sets of BLS, the associations to the past diminish in their emotional intensity. The therapist redirects Jon’s attention to the current Target Memory of being anxious about going outside. “What comes up now?” the therapist asks. “I’m not as panicked, but I’m still scared,” he replies. After several more sets of BLS while focusing on the current situation, Jon reports a SUD of 2. He further replies, “I haven’t thought about that time in my life for years. It never occurred to me how scared I was to leave the house. This makes a lot more sense now.” After another couple of additional sets of BLS the SUD was a 0. The installation of the PC, “I can be safe now,” was a VOC of 7 with a clear body scan. When the therapist invited him to imagine opening the front door of his house and going outside, he replied, “How about we start with going outside in the back yard first? That seems more doable to me.” “Of course,” the therapist replied. The session ended with a Future Template of going outside in his back yard with the positive belief of, “I can be safe now,” and feeling the congruence of the experience of safety in his body.

The next session starts with the Reevaluation Phase, and Jon reports having a greater sense of calm over the week. The original Target Memory is revisited to determine what Jon experiences when he brings it to mind. Jon replied, “I can actually see myself going out into the front yard and maybe even to the end of the block.” The therapist decides to generate another

Future Template of walking outside to the end of the block, feeling confident that in the ensuing week he could go further. The PC is, "I am safe now." The therapist and client develop a couple of challenge situations, like being on the sidewalk with a group walking behind him similar to the middle school experience, and he was able to imagine it with a minor concern over maintaining a social distance. When checking with Jon about the earlier experiences that came up in the processing, he remarked that it made him sad that he was alone in those experiences and that he never knew that his current sense of fear was derived from his experiences in grade school and in his childhood home. He attributed his behavior to being "shy" and "socially awkward," rather than anxious. Since that time, he is able to take long walks in the neighborhood, sometimes alone and other times with his wife, occasionally initiating small talk with neighbors with whom they are becoming more acquainted.

Case Two: Brief Intervention for Acute Stress Symptoms

"Dana" is an emergency room physician who is working additional shifts due to the COVID crisis. At the recommendation of a fellow doctor who had a positive treatment experience with EMDR therapy, Dana reached out for help. She reports having difficulty sleeping, nightmares, intrusive thoughts, difficulty concentrating, anxiety, agitation, and is quick to anger. She describes several occasions where she became defensive with her patients when the treatments she administered were unsuccessful. Even some of her co-workers expressed concern. She is also worried that her exhaustion, due to working long hours, would increase her risk of making an error in judgment that could be life-threatening to her patients. She reports a recent incident where she administered an experimental treatment to the COVID patients who became even more ill than they were before they received the treatment. This was the recent experience that prompted her to seek EMDR therapy for her symptoms.

Since Dana is initiating treatment at the height of the pandemic in her area and the stay-at-home orders were already in place, therapy was conducted virtually from the beginning. Further, the only private place to meet was from her car using her smartphone due to several children at home, as there was no space for her without the risk of the session being disrupted. The client purchased a piece of equipment for the administration of the BLS in order to simultaneously maintain the image of the therapist on her phone screen.

In the history-taking, Dana describes multiple scenarios at the hospital that represent her overriding experience that no matter what she does, "it isn't enough." Her EMDR therapist, of course, hears her comment as past and present tense, and queries her about the familiarity of that experience. Dana goes on to affirm that, in fact, she felt that way a lot as a child of parents who were both doctors, where expectations were high and she often fell short. She describes herself as perfectionistic in a way that makes her an excellent doctor, but says that she has never had so many failure experiences all at one time at any point in her career. She says to her therapist, "I haven't felt this bad about myself in years!"

After two sessions focused on history-taking and preparation, they agree Dana is ready to proceed with memory processing. Dana preferred to start memory processing with the Target Memory of being late for a meeting with a patient who became very angry with her. The image is the angry look on the patient's face as she arrived. NC is, "I'm not enough"; the PC is, "I am enough." The VOC on the PC is 1; the emotions are anger and frustration; the SUD rating is a 5; and the body sensations are a pit in her stomach. In the first few sets of BLS, Dana reflects on the current experience with the patient who is angry with her. As her own anger subsides, she reports feeling more shame. In the standard processing sequence, the therapist encourages the client to "Go with that." In this case, however, the therapist recognizes her response to the current situation as a past-present moment where Dana's experience of her feelings of shame is informed by an earlier set of experiences that are not coming up spontaneously, as is often the case when the Target Memory is a recent and compelling experience. The therapist instead proceeds to confirm her impression and asks, "Is the shame you're describing a familiar reaction for you?" "Yes," she replies. The therapist, who now has a confirmation from the client that this is indeed, a past-present moment, initiates the Floatback technique as a cognitive interweave, a therapist-initiated intervention (Shapiro, 2018). After the next set, two significant failure experiences during her residency come to mind and the processing continues to unfold without further intervention. Both are memories where Dana's medical interventions likely contributed to a patient's death. Once the emotional charge to these associations subside, the therapist redirects Dana back to the Target Memory of the angry patient. The focus of the remainder of the processing session is on the Target Memory itself, asking the client to reflect on how the memory is changing, or how her orientation to it is shifting. No further

channels of associations are accessed, which is also a departure from the standard processing procedures. Instead, the therapist deliberately narrows the client's focus of attention on the remaining aspects of the Target Memory until the client reports no new changes and the SUD is 0. The therapist, following standard procedures, installs the PC of "I am enough," to a VOC of 7, with a clear body scan. Following the reprocessing of this current trigger, the therapist immediately proceeds with a Future Template of having Dana imagine her response to a similar situation in the future. Dana is more matter of fact about it, and replies, "I can see more clearly now how anxious he was about his health," no longer taking the patient's reaction personally. Instead, she was able to have empathy for her patient who was struggling to face the seriousness of his medical condition.

Upon reevaluation in the next session, Dana reports feeling significantly better since the initial processing session. The nightmares subsided, she is sleeping better, is better able to concentrate, and her mood has improved. When asked about the Target Memory of being yelled at by the patient for being late to the meeting, she shrugs, commenting, "I would have been irritated by me, too, if I were facing a severe illness." The therapist also asks about two memories from residency that had emerged in the previous session to see if there is any residual distress or confusion about them. "No," she replies. I was a resident who was learning to perform these procedures for the first time. How else does anyone learn? I don't have to be hard on myself the way my parents were. I was learning then, and I'm still learning now."

In the weeks that passed, Dana continued to report an increased sense of well-being and a renewed interest in her work, despite ongoing challenges and treatment failures with her COVID patients. She reported being late for another patient who also became angry with her tardiness. She was pleased to report that she responded, "apologetically and with compassion," to her aggrieved patient.

Case Three: Application Within EMDR Psychotherapy

Emma is a 30-year-old woman who initiated therapy 9 months earlier after relocating to a new area and starting a job. While struggling to make a new life for herself, she was trying to maintain an on-again, off-again long-distance relationship with her boyfriend. She is the youngest of two children who grew up with a father who was a rageful alcoholic, and describes her

mother as mostly preoccupied with her marriage, failing to protect her daughters from their father's mercurial moods and out-of-control rages while drinking. Meanwhile, Emma spent a lot of time alone as a child and developed a drug and alcohol addiction herself as a means of managing her anxiety, dread, and sense of uncertainty due to the unpredictability of what would happen at home. She has many strengths, most notably that she has been in recovery from all substances for 7 years without a relapse. Before the stay-at-home orders were given during the COVID crisis, Emma had successfully ended her relationship with her long-distance boyfriend, made a couple of new friends, settled into her work environment, and was spending more time with her sister's family. With the orders, she had to stay at home alone.

The COVID crisis changed her life circumstances dramatically. Just as she was enjoying her new job, getting used to being single, and enjoying her social network of peers, she is now relegated to being home alone. Emma reports feeling increasingly anxious, lonely, isolated, and bored. Therapy sessions have been conducted online for a month at this juncture.

Shortly into the second month of quarantine, Emma reports concern about her online shopping behavior. She was spending several hours every evening looking at yoga outfits, spending money unnecessarily. While she often returns many of the items she purchases, she continues to spend enough time and money on this activity that it warrants concern. In the 60-minute session that followed, they decided to target the current scenario for processing. The Target Memory is buying clothing on the computer the evening before. The image is seeing herself sitting in front of her computer screen with a blank look on her face. The NC is, "I am alone." The PC is, "I'm not alone anymore. I have people in my life today." VOC 3 (out of 7). As a point of clarification, the NC of "I am alone" for this client is a conclusion, not a description. The emotions are sadness, anxiety, and shame. The SUD is 9 (out of 10) and the body sensation is a pit in her stomach.

The processing starts with Emma focusing on her mind-numbing activity of shopping, while quickly shifting into feeling shame and reacting with judgment towards herself for indulging in the shopping and allowing it to get out of control. After the second set of BLS, the therapist asks a question in the form of a cognitive interweave: "That's a familiar feeling, isn't it?" (Again, here is the clinical choice point, based on the therapist's judgment.) "Yes," she replies. The therapist initiates the Floatback technique to facilitate access to earlier associations. After another set of BLS,

Emma describes a typical childhood scene where she is 12 years old and alone in her room for the remainder of the day because she had a violent temper tantrum in response to her father's drinking. The processing continues for several more sets, mostly focused on this experience and the recognition that it happened often. There were other scenes that were vague fragments of memories related to the 12-year-old's experience of being anxious and alone. Once the earlier scene had diminished in intensity, we returned to the Target Memory of shopping compulsively online. It, too, was not disturbing. She describes having more appreciation for why she was shopping and felt more compassion for both her younger self as well as her adult self, having a more adult perspective on her pattern of behavior that was left over from childhood. The SUD was a 0, and the PC, "I'm not alone anymore. I have people in my life today," was installed to a VOC of 7. She also added, "...and I can take better care of myself now than I did when I was a kid." The therapist then invites her to imagine herself at home the next night, asking her to imagine what she would be doing instead (Future Template). Her response was to call a friend. The Future Template was installed as a movie with the positive belief from the Target Memory, "I am not alone anymore. I have people in my life today," and was able to imagine herself engaged in a conversation with this friend.

At the beginning of the next session, in the Reevaluation Phase, Emma reports that she did not feel the compulsion to shop at all that week, except for the last two nights. While she resisted acting on the urge, she wanted to work on feeling calm and comfortable at home at night. The therapist also checks on the feeder memory that came up in the Floatback during the previous session and it "wasn't as disturbing, but it wasn't calm." The therapist decides to use the past experience of being 12 years old and targets it directly in the subsequent session. This decision was made collaboratively with Emma based on her feedback that her current anxiety has more to do with her difficulty being alone, which is a pervasive childhood theme. After the feeder memory of being alone in her room was resolved, Emma reports no more urges to shop online and has returned most everything she bought during that month-long "binge."

Clinical Considerations

As is evident from the case illustrations, the EMDR Life Stress Protocol can be applied as a stand-alone intervention, offering brief treatment to help clients adjust to an ongoing life stress or crisis, or it can be

applied as part of a more comprehensive EMDR psychotherapy. If a client is already in an ongoing EMDR psychotherapy and a life crisis develops, the application of this protocol would be in the context of an already existing relationship where client and clinical variables have already been determined, allowing for greater flexibility to respond to the clinical need. For someone who is seeking services during an ongoing life crisis, however, specific client and clinical factors need to be considered in order to determine the best course of action that best matches the needs of the client and the clinical situation.

EMDR Life Stress Protocol as a Brief Treatment

As a brief, stand-alone treatment, this protocol can be considered as one of several options, such as an EMDR recent event protocol, Eye Movement Desensitization (EMD, an abbreviated version of standard procedure; Shapiro, 1989, 2018), the full standard EMDR protocol, or even a combination of some of the above. Specific client and clinical factors inform the therapist's decision whether the problem can be addressed in a brief, short-term approach. These include the presenting problem, desired outcome, and degree of client stability, all variables that are part of any comprehensive clinical assessment and treatment plan.

The EMDR Life Stress Protocol is designed to address life challenges and disturbing situations that, most often, would not be considered a Criterion A traumatic event. The goal of the Life Stress Protocol is to reduce general distress and eliminate dysfunctional behaviors and responses. The recent event protocols and EMD were developed to reduce PTSD symptoms and reactions after a critical incident. The early interventions typically target the recent event, and limit or prevent associations to associated historical traumas. The EMDR Life Stress Protocol briefly accesses the historical memory network to link into the maladaptive memories that are driving current reactions. Clients presenting with flashbacks and intrusive memories of a traumatic event might be best treated with a recent event protocol, while clients presenting with recent malaise, anxiety, problem behaviors, and rumination might benefit from the EMDR Life Stress Protocol.

Dana, who sought treatment specifically in response to her current crisis at work, was able to both reprocess the current experiences that were generating her symptoms and develop alternative patterns of response that were more adaptive to her in responding to the ongoing stressors at work. Dana's presenting problem was very specific and circumscribed. Her

goal was to restore her capacity to perform her duties as an emergency room physician. While her situation was highly stressful and ongoing with no end in sight, the therapist accurately assessed the client's capacity and readiness for processing. That included accessing some of Dana's earlier history as evidenced by the client's ability to reflect on the past-present connections during the history-taking without getting overwhelmed. Additionally, the Safe/Calm Place installation during the Preparation phase went well (Shapiro, 2018), as she had no observable difficulty shifting from a state of relative calm to a state of activation and back to a state of calm. Jon had more difficulty with self-regulation skills, as evidenced by his anxiety. However, he was sufficiently motivated to proceed with memory processing as he understood that the momentary distress of the treatment demands would yield longer-term relief from his anxiety. Jon's premorbid level of functioning was also high prior to the onset of the pandemic, so he was a good candidate for the EMDR Life Stress Protocol as his previous functioning indicated a level of stability to tolerate the processing demands with limited access to past memories that are disturbing.

Clinical factors are always important, but particularly if the therapist does not have a history with the client and treatment is short-term. These include a solid therapeutic alliance, a collaborative stance, and therapist flexibility. For example, Dana and her therapist established a "good enough" therapeutic alliance when she expressed concern about the potential side effects of this methodology, and they were able to address the client's concern to her satisfaction. Dana was willing to trust that her therapist would keep her emotionally "safe enough" to allow for processing to occur. Next is a collaborative stance which speaks to the importance of negotiating the "terms of engagement," which is about a shared understanding about how the therapist and client are going to work together. In Dana's case, it was agreed that the client would make contact with the therapist if she was struggling between sessions so a course of action could be determined based on the client's need. This is particularly important with clients who are accustomed to managing stress on their own and are uninclined to reach out for help, such as frontline healthcare workers and first responders.

For clients whose prior level of psychosocial function is more compromised, however, due to a combination of external and internal variables, opening up earlier memory networks could risk further destabilization. That does not mean this approach should not

be used; however, it does require the therapist to be more active in their use of cognitive interweave strategies to limit access to associations and redirect the client back to the Target Memory more frequently. In these cases, maintaining a more narrowed focus to the processing would be key to achieving successful treatment results, especially in a brief, short-term approach. Perhaps a better choice would be a protocol that limits earlier associations altogether, especially for clients who are more chronically unstable and are "high accessors." These are clients who respond to memory processing by accessing a number of earlier associations with greater rapidity, making it more of a challenge to limit access and narrow the focus. Other variables such as time constraints, schedule variability, and limited access to resources such as healthcare, childcare, food, and transportation, would also argue for a brief, short-term approach that limits past associations to recent events and ongoing life stressors.

Another factor is the client's readiness and willingness to open up earlier memories. In the case of the emergency room doctor, when the therapist asked Dana if she had any concerns about proceeding with memory processing, she stated, "I don't want to open everything up in the past and not be able to put it back in its box again. I need to be able to work." The therapist assured her that she would be managing her processing experience with that in mind, and the client was free to stop at any point if she had any concerns. Some clients, however, do not want to touch on past memories for reasons that are understandable, especially in a crisis, so a recent events protocol might be more appropriate. For clients who will only be seen for a very limited number of sessions (1–3), opening up linkages to other associated memories would not be indicated without an opportunity for follow-up, as in cases of in vivo treatments.

EMDR Life Stress Protocol as Part of an Ongoing EMDR Psychotherapy

As described earlier in this article, this author originally developed this protocol to be used as part of an ongoing EMDR psychotherapy for attachment issues. Sometimes these earlier memories can be identified for processing, while other times they are not as accessible due to the nature of these memories, combined with the client's early survival strategies, such as avoidance, minimization, or dissociation (Knipe, 2018). Over time, these maladaptive patterns of response can become habituated, generating additional stress in the client's life. This protocol uses these patterns of

responses as a focus of treatment. However, this protocol can also be applied to address inherent stressors that arise during an ongoing crisis that may or may not be part of the original treatment plan, such as feeling anxious about going to work during COVID or living alone and feeling isolated.

A client factor that could be used to determine whether or not this protocol could be applied is to explore to what extent the client is responding optimally to the inherent life stressors. Emma was not responding well after a month of living alone without any physical contact with anyone. Her coping strategy was a variation of an old pattern of compulsive behavior in order to self-soothe. While clearly not as destructive as drinking alcohol and using drugs, it was important to address the compulsive shopping before it escalated over time, as one might expect in an ongoing crisis situation. Just as the client's premorbid level of functioning is a variable in brief treatment, it is also a variable for ongoing EMDR psychotherapy. Emma, for example, had a pervasive history of complex developmental trauma, which for some therapists would be a reason to offer a resourcing strategy, such as Resource Development and Installation (RDI) (Korn & Leeds, 2002) as one example, based solely on her history and the inherent life stress she was experiencing. However, her level of functioning prior to the onset of the pandemic was excellent, which argued for a clinical intervention more commensurate with her capacities. Given that she had been in EMDR psychotherapy for 9 months with many traumatic memories resolved and integrated into an adult narrative, the clinical decision to target current situations and deliberately access the feeder memories was straightforward. This protocol also allows for a pivot point in an ongoing therapy to address maladaptive coping behaviors from the past due to a current life stress. While there may already be a treatment plan in place with an existing client, contracting for more immediate, short-term goals, as was the case with Emma, will redirect the focus in order to develop more adaptive patterns of response to their life stress.

It is important to emphasize that, while this author is describing an approach that lends itself well to a crisis situation, it also offers another way to address problems in daily living. This approach is informally taught and commonly used by clinicians in EMDR psychotherapy, particularly those who work with complex developmental trauma (Deborah Korn, personal communication, April 2020). While the general consensus is to begin EMDR therapy with the standard protocol, that is, targeting early memories related to

current difficulties, it is important to consider how and when modifications can be made in order to best meet the needs of our clients. Targeting present-day situations, particularly as therapy evolves over time, allows for a more pointed approach. Consider the rationale of beginning treatment with the Touchstone Memory, the earliest memory the client can remember. Shapiro argued that targeting the Touchstone Memory addresses the "root cause" of the client's difficulties (Shapiro, 2018, p. 137), facilitating greater generalization effects by casting a wider net into the memory network. Using the same rationale, targeting present-day difficulties directs the brain to associations more closely linked to the client's current difficulties, as illustrated by Dana's two failure experiences during her residency that were directly linked to her current difficulties in her role as an emergency room physician.

Discussion

As elaborated in this article, the EMDR Life Stress Protocol proposes simple but significant modifications to the standard protocol in an attempt to address the ongoing stress of current experiences, concerns, and challenges that impact an individual's ability to respond optimally in a crisis. It is not uncommon for anyone, under prolonged periods of life stress, to resort to earlier and less effective coping strategies, especially when there is limited ability to control for environmental factors that play a major role in the individual's response, impacting their level of psychosocial functioning. Additionally, when the client plays an important societal role, as in the case of the emergency room physician, time is of the essence, both for the well-being of the client and for the public who depends on their ability to perform their duties under adverse conditions. While medical professionals and other frontline healthcare workers and first responders are accustomed to working under adverse conditions, these times are truly unprecedented. When these workers who have devoted their lives to saving others do not have the medical means, the technology, or the personal protection equipment to do their jobs, they are at significant risk for being traumatized. An additional stressor, of course, is the risk to themselves and their families while working under these conditions, where the exposure is high and they are likely to be quarantined, which makes them even more vulnerable to traumatic stress symptoms or PTSD. A brief, short-term approach, such as

the EMDR Life Stress Protocol would offer immediate and long-lasting relief, allowing the client to recover their capacity to continue to navigate these ongoing demands that are unrelenting.

In conclusion, the EMDR Life Stress Protocol is well suited for clients who are struggling with present-day challenges due to an ongoing life stress or crisis situation such as COVID. It can be used as a standalone, brief treatment, or as an integral part of EMDR psychotherapy. In either application, the goal is to address the client's maladaptive pattern of response due to the activation of an old coping strategy in favor of a more effective response, optimizing their ability to effectively cope with the ongoing life stress. The expected outcome is to improve the client's overall level of psychosocial functioning, thereby increasing the likelihood of responding appropriately to future situations that are similar. If the therapist determines, based on their clinical assessment, that the client is a good candidate for EMDR therapy and is sufficiently motivated to feel and respond better, they will likely do well with this approach. Scheduling additional session time if needed to ensure complete resolution of the Target Memory followed by a Future Template is ideal. However, adding an additional session or sessions later in the week as needed also serves the important purpose of developing these alternative patterns of response to the life stress, producing more robust treatment effects. This, in turn, will invariably increase the client's level of stability and resilience to respond more effectively and proactively to the ongoing life challenges in the present and future.

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